

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395525</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>04/25/2023</b>
NAME OF PROVIDER OR SUPPLIER: <b>IVY HILL POST ACUTE NURSING &amp; REHABILITATION LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1401 IVY HILL ROAD WYNDMOOR, PA 19150</b>		
STATE LICENSE NUMBER: <b>591902</b>					
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F 0000	INITIAL COMMENT	F 0000			
F 0690	Based on an Abbreviated Survey in response to a complaint, completed on April 25, 2023, it was determined that Ivy Hill Post Acute Nursing and Rehabilitation, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0690			
SS=G					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0690  SS=G	Continued from page 1  483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.  §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.  §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	Preparation & execution of this preparation of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both federal and state.  Element 1 -Corrective action Resident RI lab drawn during hospital stay.  Element 2 Identification of at Risk Residents  All residents with indwelling catheters have the potential to be affected.  Element 3 Systemic Changes  Unit Manager/Designee will review resident charts with urinary catheters to ensure that laboratory testing was completed timely in the past 14 days and follow up with	Completion Date: <b>05/16/2023</b> Status: <b>APPROVED</b> Date: <b>05/12/2023</b>	

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F 0690  SS=G	Continued from page 2  This REQUIREMENT is not met as evidenced by:	F 0690	<p>physician as needed for any concerns identified.</p> <p>A contracted state approved vendor will initiate directed in servicing to all licensed nurses on the lab process including the need to obtain labs for a resident with an indwelling urinary catheter in a timely manner.</p> <p>Newly hired licensed nurses will receive education during orientation, annually and prn.</p> <p>Newly admitted residents will be reviewed in the daily clinical meeting to ensure lab orders related to indwelling urinary catheters are completed as ordered.</p> <p>Element 4 Quality Assurance</p> <p>Unit Manager/Designee will review the Order Listing Report in clinical meeting and audit weekly x 4 then monthly x 2 to ensure laboratory testing is completed timely in all residents with indwelling urinary</p>	

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F 0690  SS=G	<p>Continued from page 4</p> <p>Based on clinical record review and family and staff interviews, it was determined that the facility failed to obtain a urinary study in a timely manner for a resident with an indwelling urinary catheter and experiencing bleeding from the urinary catheter for one of five residents reviewed. (Resident R1). This failure resulted in actual harm to Resident R1 who was transferred to the hospital, diagnosed with a urinary track infection, anemia and required two units of PRBC (packed red blood cells).</p> <p>Findings include:</p> <p>Review of Resident R1's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated February 6, 2023, revealed that the resident was admitted to the facility, November 12, 2022, with diagnoses of middle cerebral artery stroke (MCA stroke may cause language deficits, as well as weakness, sensory deficits and visual defects on the opposite side of the body) and urinary tract infection (UTI is an infection</p>	F 0690			

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F 0690  SS=G	Continued from page 5  in any part of the urinary system including the kidneys, ureters, bladder and urethra). Continued review of the MDS revealed that the resident had short and long term care memory impairment, required extensive assistance with bed mobility and transfer and had an indwelling urinary catheter.  Review of Resident R1's care plan initiated November 13, 2022, revealed that the resident had the potential for complications related to the use of foley catheter with a supporting diagnosis for the use of a foley catheter due to a sacral pressure ulcer. Interventions included to observe foley catheter for signs and symptoms of a UTI.  Review of Resident R1's nursing notes dated April 8, 2023, at 7:29 p.m. by licensed nurse, Employee E11, "Nurse received resident in bed with foley catheter draining bright red blood, and during incont (incontinent) care the resident's diaper was saturated with bright red blood along with bright red blood clots small to largest the size of a quarter. Resident appeared to be in no pain no distress."	F 0690			

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F 0690  SS=G	<p>Continued from page 6</p> <p>A review of Resident R1's hospice documentation revealed that the resident was admitted to hospice services on November 12, 2022. Continued review of R1's hospice record revealed a note dated April 8, 2023, stating that there was a change in condition with the bleeding from the foley catheter.</p> <p>Review of Resident R1's nursing note dated April 9, 2023, at 3:29 a.m. by Licensed nurse, Employee E11, revealed that the hospice nurse was in to assess resident, and during the exam the resident presented with several extra-large bright red blood clots (larger then previously) inside her incontinence brief, which was also saturated with blood, and the foley catheter was also draining bright red blood. The resident appeared to be very lethargic, even more than usual, as the resident was falling asleep during care. The hospice nurse indicated that she would have another nurse out in morning to follow-up.</p> <p>Review of nursing note date April 10, 2023, at 3:10</p>	F 0690			

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F 0690  SS=G	<p>Continued from page 7</p> <p>p.m. by Licensed nurse, Employee E9, revealed that hospice had made a recommendation for obtaining UA C&amp;S (urine analysis with culture and sensitivity test used in diagnosing urinary tract infections, especially in patients who have a catheter inserted for an extended period of time) to rule out a UTI (urinary tract infection) related to a change in condition and hematuria (blood in the urine). The "MD's (physician) office and daughter were made aware. Nursing to monitor."</p> <p>Continued review of nursing documentation dated April 10, 2023, at 9:18 p.m. by Licensed nurse, Employee E12, noted that urine specimen was obtained and placed in the refrigerator for the UA C&amp;S test to diagnose a UTI.</p> <p>Further review of Resident R1's clinical record revealed no nursing note written on April 11, 2023, indicating that nursing was monitoring the change in condition with blood in the foley catheter and bright red blood and blood clots in the resident's incontinent brief.</p>	F 0690			

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F 0690  SS=G	Continued from page 8  Review of nursing note dated April 12, 2023, at 1:54 p.m. revealed that Resident R1's daughter was present "at the nurse's station with concerns about her mother related to her hematuria and increased trach secretions. Call was placed to MD office to approve recommendation by hospice for a UA C&S. Awaiting call back from office." Nursing note dated April 12, 2023, at 5:40 p.m. noted that the physician's office contacted the facility with verbal orders for a UA C&S collection.  Continued review of nursing documentation dated April 13, 2023 at 2:57 p.m., revealed that Resident R1's daughter requested that the resident be sent out to the hospital related to increased secretions and hematuria.  An interview with the Resident R1's daughter, who is the resident's responsible party, at the facility on April 25, 2023, at 12:50 p.m. revealed that the daughter was frustrated that it took the facility too long to diagnose and treat her mother for a UTI	F 0690			

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F 0690  SS=G	Continued from page 9  which she, and everyone she spoke with was sure was causing her mother's bleeding in her Foley catheter, and her lethargy and sleeping through her visits which was not her norm. She stated that she pointed out the purple red urine in her mother's catheter bag every time she visited and how her mother's condition had continued to decline from when she first was aware of the bleeding on April 8, 2023, until she demanded that she be sent out to the hospital on April 13, 2023, because the still did not have any lab results and were not treating her mother's UTI. Resident R1's daughter was upset and said that her mother had to receive a transfusion of two units of blood once she got to the hospital.  Review of Resident R1's hospital records dated April 21, 2023, revealed a urinalysis laboratory test completed 4/13/23 which indicated that the resident urine color was red and large content of blood. Continue review of hospital records revealed a CBC (complete blood count) which revealed a Hemoglobin level of 5.2 grams (gm)/per deciliter (dl) normal 12g/dl-16g/dl) and a Hematocrit level of	F 0690			

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F 0690  SS=G	<p>Continued from page 10</p> <p>16.6% (normal levels 35.5 to 44.9%). Review of the iron panel revealed results which were consistent with iron deficient anemia, likely from bleeding. Resident R1's daughter consented for blood transfusion, and that 2 units PRBC (packed red blood cells are a type of blood replacement product used for blood transfusions. PRBC transfusion is typically given in situations where the patient has either lost a large amount of blood or has anemia that is causing notable symptoms) were transfused.</p> <p>Interview with Licensed nurse, Employee E9, Unit Manager on April 25, 2023, at 1:20 p.m. revealed that the facility became aware of the bleeding on April 8, 2023, which she pointed out was a Saturday. Hospice recommendation for a UA C&amp;S was on April 10, 2023, and that the facility collected a sample that day. That it can take a day or two for results and when the daughter visited on April 12, 2023, asking about the results she called that lab who said that they never received the sample. Licensed nurse, Employee E9 got an order to</p>	F 0690			

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F 0690  SS=G	Continued from page 11  collect another urine sample to send out for a UA C&S. That a sample was collected on April 12, 2023, but that it had not been picked up by the lab yet when the daughter arrived on April 13, 2023, demanding that her mother be sent out to the hospital.  Interview with the Director of Nursing (DON) on April 25, 2023, at 2:15 p.m. confirmed that Resident R1's change in condition related to bleeding in her catheter and blood clots in her brief started on April 8, 2023, and that a urine sample was collected on April 10, 2023, at 10:30 p.m. and that it was picked up the next morning (April 11, 2023) and that when the Licensed nurse, Employee E9 called on April 12, 2023, she was told that it was not received by the lab, and that another order was initiated but it was not processed before the daughter insisted her mother be sent out. The DON confirmed that the change in condition was noted on Saturday, April 8, 2023, and that Resident R1 was sent out to the hospital six days later on Thursday, April 13, 2023, and that the resident never had UA	F 0690			

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F 0690  SS=G	Continued from page 12  C&S results or treatment with antibiotics during this time.  The facility failed to ensure that laboratory testing was completed timely for a Resident R1 with urinary catheter who experience bleeding from the catheter and presented with blood clots. This failure resulted in actual harm to Resident R1 who was transfer to the hospital, diagnosed with a urinary tract infection and anemia and required two units of PRBC.  28 Pa. Code:201.18(a)(b)(1)(3) Management  28 Pa Code 211.119c) Resident care policies  28 Pa. Code:211.12(d)(1)(5) Nursing services	F 0690			

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F 0770  SS=D	Continued from page 14  483.50(a)(1)(i) Laboratory Services  §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.  This REQUIREMENT is not met as evidenced by:	F 0770	Preparation & execution of this preparation of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both federal and state.  Element 1 -Corrective action R1 labs obtained by hospital and R3 labs obtained timely by facility and reported to physician without further recommendations.  Element 2 Identification of at Risk Residents All residents with physicians order for laboratory services have the potential to be affected  Element 3 Systemic Changes Unit/Designee will review order listing report x last 2 weeks to ensure facility obtained lab services in a timely manner  Element 4 Quality Assurance	Completion Date: <b>05/16/2023</b> Status: <b>APPROVED</b> Date: <b>05/12/2023</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395525</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>04/25/2023</b>
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F 0770  SS=D	Continued from page 15	F 0770	Staff Development/Designee will in-service licensed nurses on facility lab process. Unit Manager/Designee will review order listing report in clinical meeting and audit weekly x4, monthly x2. Audit findings will be reported to QAPI monthly x3.		

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F 0770  SS=D	<p>Continued from page 16</p> <p>Based on review of clinical record and interviews with staff, it was determined that the facility failed to timely obtain laboratory services for two of three residents reviewed. (Resident R1 &amp; R3)</p> <p>Findings include:</p> <p>Review of Resident R1's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated February 6, 2023, revealed that the resident was admitted to the facility, November 12, 2022, with diagnoses including, but not limited to middle cerebral artery stroke (MCA stroke may cause language deficits, as well as weakness, sensory deficits and visual defects on the opposite side of the body) and urinary tract infection (UTI is an infection in any part of the urinary system including the kidneys, ureters, bladder and urethra).</p> <p>A review of the Resident R1's clinical record revealed a nursing notes dated April 8, 2023, by Licensed nurse, Employee E11, who noted that she received Resident R1 in bed with foley catheter</p>	F 0770			

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F 0770  SS=D	Continued from page 17  draining bright red blood, and during incontinent care the resident's incontinence brief was saturated with bright red blood along with bright red blood clots with the largest the size of a quarter.  Further review of Resident R1's clinical record revealed an April 9, 2023 note written at 3:29 a.m. by Licensed nurse, Employee E11, which indicated that the hospice nurse was in to assess resident and during the exam the resident presented with several extra-large bright red blood clots (larger than previously) inside her diaper, which was also saturated with blood, and the foley catheter was also draining bright red blood. The resident appears to be very lethargic, even more than usual, as she was falling asleep during care. The hospice nurse indicated that she would have another nurse out in morning to follow-up.  Review of a verbal statement taken by the Director of Nursing on April 25, 2023, from the Employee E13, attending physician, at 2:30 p.m. revealed that that he had been contacted by the hospice provider	F 0770			

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F 0770  SS=D	Continued from page 18  regarding a change in condition for Resident R1, for hematuria (blood in the urine) in her foley catheter, and that he gave an order to collect urine for a UA (urinalysis) C&S (urine analysis with culture and sensitivity test used in diagnosing urinary tract infections, especially in patients who have a catheter inserted for an extended period of time and those who have painful urination, and is used to find out the specific germs causing the infection and to determine the most effective medication to use for treatment).  Review of nursing note dated April 10, 2023, Licensed nurse, Employee E9, revealed that hospice had made a recommendation for obtaining UA C&S to rule out a UTI (urinary track infection) related to a change in condition and hematuria (blood in the urine).  Review o of nursing note April 10, 2023, revealed that urine was obtained and placed in the refrigerator for the UA C&S test to diagnose a UTI.	F 0770			

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F 0770  SS=D	<p>Continued from page 19</p> <p>Review of an April 12, 2023, at 1:54 p.m. revealed that Resident R1's daughter was present at the nurse's station with concerns about her mother related to her hematuria and increased trach secretions. A call was placed to the physician's office to approve a recommendation by hospice for a UA C&amp;S and that she was waiting for a callback from the physician's office. Continued review of nursing notes revealed that on April 12, 2023 at 5:40 p.m. revealed that the facility she was contacted by physician's office and received and entered a verbal order for a UA C&amp;S collection.</p> <p>Review of an April 13, 2023, nurse revealed that Resident R1's daughter requested that her mother be sent out to hospital for observation related to increased secretions and hematuria.</p> <p>An interview with the Resident R1's daughter, who is the resident's responsible party, at the facility on April 25, 2023, at 12:50 p.m. revealed that the daughter was frustrated that it took the facility too long to diagnose and treat her mother for a UTI</p>	F 0770			

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F 0770  SS=D	<p>Continued from page 20</p> <p>which she, and everyone she spoke with was sure was causing her mother's bleeding in her foley catheter, and her lethargy and sleeping through her visits which was not her norm. She stated that she pointed out the purple red urine in her mother's catheter bag every time she visited and asked for the urine to be tested since she became aware of the bleeding on April 8, 2023, until she demanded that she be sent out to the hospital on April 13, 2023, because the still did not have any lab results and were not treating her mother's UTI. Resident R1's daughter was upset and said that her mother had to receive a transfusion of two units of blood once she got to the hospital.</p> <p>A review of Resident R1's hospital records dated April 21, 2023, revealed lab tests, including iron panel with results which were consistent with iron deficient anemia, likely from bleeding. Resident R1's daughter consented for blood transfusion, and 2 units PRBC (packed red blood cells are a type of blood replacement product used for blood transfusions. PRBC transfusion is typically given in</p>	F 0770			

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F 0770  SS=D	<p>Continued from page 21</p> <p>situations where the patient has either lost a large amount of blood or has anemia that is causing notable symptoms) were transfused.</p> <p>Interview with Licensed nurse, Employee E9, on April 25, 2023, at 1:20 p.m. revealed that the facility became aware of the bleeding on April 8, 2023, which she pointed out was a Saturday. She said that hospice recommendation for a UA C&amp;S was on April 10, 2023, and that the facility collected a sample that day. She said that it can take a day or two for results and when the daughter visited on April 12, 2023, asking about the results she called that lab who said that they never received the sample. The UM said that she then got an order to collect another urine sample to send out for a UA C&amp;S. She said that a sample was collected on April 12, 2023, but that it had not been picked up by the lab yet when the daughter showed up on April 13, 2023, demanding that her mother be sent out to the hospital.</p> <p>Interview with the Director of Nursing (DON) on</p>	F 0770			

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F 0770  SS=D	Continued from page 22  April 25, 2023, at 2:15 p.m. confirmed that Resident R1's change in condition related to bleeding in her catheter and blood clots in her brief started on April 8, 2023, and that a urine sample was collected on April 10, 2023, at 10:30 p.m. and that it was picked up the next morning (April 11, 2023) and that when Licensed nurse, Employee E9 called on April 12, 2023, she was told that it was not received by the lab, and that another order was initiated but it was not processed before the daughter insisted her mother be sent out. The DON confirmed that the change in condition was noted on Saturday, April 8, 2023, and that Resident R1 was sent out to the hospital six days later on Thursday, April 13, 2023.  Review of Resident R3's Quarterly MDS dated April 5, 2023, revealed that the resident was admitted to the facility, October 9, 2022, with diagnoses including, but not limited kidney transplant and an elevated white blood cell count.  A review of an April 18, 2023, progress note	F 0770			

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F 0770  SS=D	<p>Continued from page 23</p> <p>written at 11:27 a.m. revealed that Resident R3 need bloodwork and a urine analysis for her appointment with kidney transplant program, labs put in lab book and Licensed nurse was made aware.</p> <p>A review of facility lab report for Resident R3 revealed urinalysis collection date of April 20, 2023, at 7:00 a.m. and a first report date of April 21, 2023.</p> <p>Interview with the Director of Nursing (DON) on April 25, 2023, at 2:15 p.m. confirmed that Resident R3's labs, including urinalysis, were ordered on April 18, 2023, and the sample was not picked up till April 20, 2023, and that the results were not available until April 21, 2023, over three days later.</p> <p>28 Pa. Code 211.10(a)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing</p>	F 0770			

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F 0770  SS=D	Continued from page 24  services			F 0770			



# Certified End Page

**IVY HILL POST ACUTE NURSING & REHABILITATION LLC**

**STATE LICENSE NUMBER: 591902**

**SURVEY EXIT DATE: 04/25/2023**

**I Certify This Document to be a True and Correct Statement of Deficiencies and  
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

*Jeane Parisi*  
*Deputy Secretary for Quality Assurance*

A handwritten signature in black ink that reads "Debra L. Bogen MD".

*Debra L. Bogen, MD, FAAP*  
*Acting Secretary of Health*



THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY